

THE PRINCIPLE OF NORMALIZATION: A
FOUNDATION FOR EFFECTIVE SERVICES

by

John O'Brien

GEORGIA ADVOCACY OFFICE

1447 PEACHTREE STREET, N. E., SUITE 8 11

ATLANTA, GEORGIA 30309

January 1980

INTRODUCTION	1
WHAT IS NORMALIZATION	1
WHY IS THE NORMALIZATION PRINCIPLE IMPORTANT?	5
VICIOUS CIRCLES	6
IMPLEMENTATION OF THE NORMALIZATION PRINCIPLE	10
CONDITIONS CONTRIBUTING TO DEHUMANIZATION	11
Space and Settings	11
Groupings and Practices	12
Language	12
ENHANCING DIGNITY AND INDIVIDUAL RESPECT	13
Individualization	13
Developing Choices	14
Positive Interactions	15
CONDITIONS CONTRIBUTING TO AGE-INAPPROPRIATENESS	16
Space and Settings	17
Groupings and Practices	17
Language	18
ENHANCING AGE-APPROPRIATENESS	19
Program Scheduling	19
Activity Selection	19
Individual Program Plans	20
CONDITIONS CONTRIBUTING TO ISOLATION	22
Space and Settings	22
Groupings and Practices	23
PARTICIPATION	24
Physical Presence	24
Social Participation	24
PRINCIPLES INTO PRACTICE	25
PUTTING IT TOGETHER	26
"BUT, AREN'T THERE SOME CONTRADICTIONS?"	28
CONTRADICTION #1: MAKING PEOPLE NORMAL	28
CONTRADICTION #2: DENYING PEOPLE SPECIAL HELP	30
CONTRADICTION #3: EXPOSING PEOPLE TO REJECTION	31
"BUT IS IT PRACTICAL?"	32
LEARNING MORE ABOUT NORMALIZATION	32
REFERENCES	34

INTRODUCTION

The principle of normalization is a foundation for planning and operating human services and a vantage point for judging service quality. This paper defines the principle of normalization and highlights program features which influence the quality of life it supports for those it serves.

WHAT IS NORMALIZATION?

The most useful general statement of the normalization principle is this one, offered by Wolf Wolfensberger (1977).

NORMALIZATION IS...

THE UTILIZATION OF CULTURALLY VALUED MEANS IN
ORDER TO ESTABLISH AND/OR MAINTAIN PERSONAL
BEHAVIORS, EXPERIENCES, AND CHARACTERISTICS
THAT ARE CULTURALLY NORMATIVE OR VALUED.

This definition calls attention to two aspects of any human service program:

1. WHAT THE PROGRAM DOES ("means" in the definition).

The physical settings used in delivering the program.

- The ways in which people are grouped for various program purposes.

The program's goals.

The activities selected to meet program goals and the way they are scheduled.

- The people who provide the program's activities and control the program's direction.
- The language used to describe the program, its activities, and the people it serves.

2. WHAT THE PROGRAM ACCOMPLISHES FOR THOSE IT SERVES ("personal behaviors, experiences, and characteristics" in the definition).

- The social competencies people develop.

The personal appearance of people in the program.

The public image of the people in the program.

- The quality and variety of the life options people experience over time. This includes choice of living arrangements, educational opportunities, leisure time pursuits, productive work roles, and other opportunities to participate in the lives of natural families and communities.

The principle of normalization, then, is concerned with where a program is going and how it is choosing to get there.

The definition requires a judgment of how program practices would be seen by typical representatives of a community. For illustration, consider that any program practice or accomplishment might fall in one of the categories suggested by this scale:*

* If it seems to you that actually measuring the extent to which a service has implemented the principle of normalization is more complicated than this, you're right. Wolfensberger and Glenn (1975) have developed PASS 3 to evaluate services in terms of the normalization principle. They distinguish 34 aspects of normalization and provide instructions for measuring each. The scale following is only to teach the general concept involved in understanding the definition.

THE PRACTICE/ACCOMPLISHMENT WOULD LIKELY BE SEEN BY TYPICAL
COMMUNITY MEMBERS AS...

/1	/2	/3	/4	/5
NEGATIVELY VALUED		NORMATIVE		POSITIVELY VALUED
peculiar; unfamiliar; odd; undesirable		familiar; typical; expectable; com- monly encountered in the social main- stream		desirable; worthy; consistent with high aspirations

In making these judgments, there are three important rules of thumb.

1. Act as a sensitive interpreter of the larger culture. This is not a judgment of what is "normal" according to some notion of psychological health, or a judgment of what is good or bad, moral or immoral in an absolute sense. The "normal" in normalization suggests a range of familiar or socially valued possibilities, not a single "right" answer.
2. Consider a practice/accomplishment in terms of a society's standards for its valued citizens. Do not judge in terms of what typically happens to society's handicapped members. The principle of normalization was developed to change habitual patterns of dealing with many handicapped people. To make this judgment you need to identify with people who are devalued and see them as possessing the full rights of citizenship and a genuine possibility for development. This will be more difficult the more different the people seem. For instance, it will be hard for many people to see an adult who has never spoken or sat upright as enough "like me" to make it possible to assess the relative value of service practice and accomplishments.
3. The focus of evaluation is not the intentions of program leaders and staff, but the actual practice and accomplishments of the program as they would be viewed by typical community members. Evaluate "what is" for the people served rather than "what ought to be" or "why things are not better".

Exercise:

To get a better understanding of the ideas underlying the normalization principle, assign a position on the scale above to each of these practices/accomplishments. Remember, you are judging from the point of view of representative community members.

Assign a "1" to practices/accomplishments that a substantial number of typical community members would value negatively, a "3" to those which would call little or no attention to themselves either way, a "5" to practices/accomplishments typical community members would value highly.

- _____ 1. Living in a locked institution unit.
- _____ 2. Living in one's own apartment with a roommate.
- _____ 3. Being an employer.
- _____ 4. Being unemployed and supported by social service benefits.
- _____ 5. Spending the day doing arts and crafts without pay.
- _____ 6. Going to a class in a public school building.
- _____ 7. Going to a class that meets in a "special school" for people who are mentally retarded.
- _____ 8. Being dirty and unkempt and wearing dirty, sloppy clothes.
- _____ 9. Being clean and neatly dressed.
- _____ 10. Drooling continuously and slurring speech.
- _____ 11. Using a wheelchair to assist mobility.
- _____ 12. Winning a competitive athletic event.
- _____ 13. Being a church leader.
- _____ 14. Being "severely mentally retarded".
- _____ 15. Having good friends who will help when you need it.
- _____ 16. Helping a friend.

Comment :

You may find it a bit uncomfortable to describe the response of typical community members to handicapping conditions. For many people being severely retarded is, itself, a negatively valued condition. Having difficulty controlling mouth, tongue and facial muscles is, in itself, negatively valued. (Many people do devalue people with major mobility problems.) These are social facts of handicapped people's lives.

The normalization principle reminds us of two things as we deal with these facts of life. First, just because a person has a negatively valued characteristic does not mean that we are justified in isolating him or her from community life or offering life conditions which are not as good as those available to typical citizens. Second, the services we offer should attempt to balance personal characteristics which are seen negatively with others which are seen positively. None of the characteristics in the exercise that identify a person as handicapped keep a person from displaying the positively valued characteristics on the list.

A person labelled "severely retarded" who has major mobility and speech problems (all characteristics which will change very slowly) presents a positive imago if she is fashionably dressed, lives in an apartment with a roommate and a personal attendant, and is productively employed wiring electronic circuit boards at a wage of \$6.00 per hour. The same person will be seen much less positively if she lives in a locked institution ward, is dirty and unkempt, and spends each day idle except for 30 minutes of "recreation therapy". All of these characteristics - appearance, activities, living place, occupation - can be substantially influenced by the service system. The principle of normalization expects a service agency to increase people's positive characteristics.

WHY IS THE NORMALIZATION PRINCIPLE IMPORTANT?

The normalization principle may be common sense, but it is not yet common practice. A study of 256 community and institutional services establishes that the typical human service performs at less than the minimally acceptable level on normalization related measures of its practices and accomplishments (Flynn, 1979).

People with mental retardation and other significant handicaps will benefit from application of the normalization principle because they are personally at risk of being devalued by our society. Devaluation occurs when a person is seen as being different and the differences are socially significant and negatively valued. Though devaluation begins in the eyes of others, social expectations can soon cause people to devalue themselves and act accordingly.

One common consequence of social devaluation is discrimination. People who are devalued are apt to be treated unfairly and unjustly because they represent a socially devalued group. Thus, handicapped people in our society are likely:

to be poor because they are unemployed or under-employed, according to the 1970 U.S. Census, 64% of all Americans with substantial mental and physical disabilities are unemployed, and 52% of people with disabilities have incomes of less than \$2,000.00 a year. The national average wage for people with mental handicaps employed in so-called "work activity centers" is reported as 34 cents an hour (U.S. Department of Labor, 1977).

- to be excluded by rule or by custom from many of the entitlements of citizenship. Before the 1978 implementation of the Education for All Handicapped Children Act, more than one million children were entirely excluded from public schooling on the basis of their handicap (Biklen and Bogdan, 1976).
- to be institutionalized, often because of a lack of effective and sufficiently resourced community services. In 1977, 151,000 people with mental retardation were living in publicly operated institutions alone, at an annual cost exceeding \$2.4 billion (Scheerenberger, 1978).

VICIOUS CIRCLES

The most extreme example of devaluation for a person is what sociologists call a "deviancy career". The way a person is seen as different becomes synonymous with the person's identity. In a way, the person's handicap becomes his/her enforced occupation.

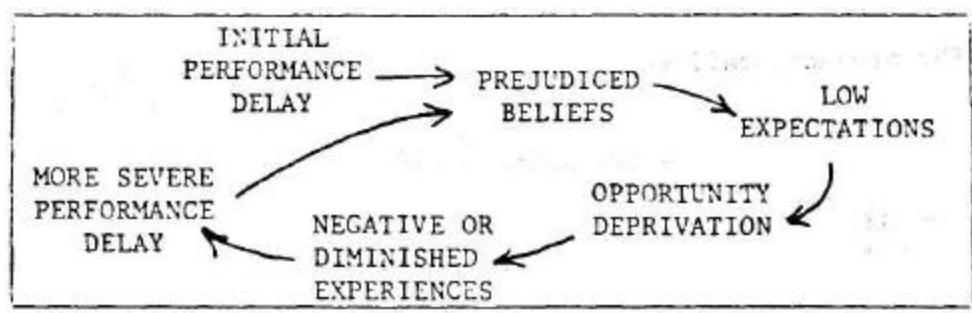
The deviancy career is a vicious circle in which a person meets widely held stereotypes and comes to embody them. Here is an example of how the vicious circle works.

- A child experiences an impairment in ability to function which is labelled "severe mental retardation".
- He and his family meet a service system which they will come to depend upon for help. The service system is designed around the belief that people who are labelled "severely retarded" are, by nature, incompetent.
- The service system advises the family that their son will always "need" custodial care, which it offers.
- The child, deprived of the expectation that he can develop competence and deprived of support and training experiences required to assist him to do so, becomes more incompetent with every passing year when compared to his age peers.
- The person's continuing incompetence justifies continued pessimism about his ability which leads to continued deprivation of learning opportunities.

The most vicious circles are the ones that begin with what "everybody knows". As far as people with handicaps are concerned, what everybody knows is likely to be an unquestioned, limiting assumption about their growth potential, about their right to enjoy opportunities, or about the capacity of others to accept and respond positively to them and their needs.

One of the strangest parts of the vicious circle is its effect on what people see. For instance, "everybody knows that young children who are severely retarded can't become a part of early education programs that serve socially valued children." When those who "know" this see children with severe retardation who are, in fact, doing just what "everybody knows" can't be, logic says that what "everybody knows" should change. But vicious circles aren't logical. What usually happens is that those who "know" deny that which contradicts prejudiced beliefs. They say, "Those children must have been mislabelled; they aren't severely retarded at all," or "Well, the severely retarded children we serve must be a lot more severely retarded than they are." Progress only begins when someone questions what "everybody knows" and turns it from a prediction that defines the future into an undesirable situation to be changed.

The vicious circle has two bad effects. First, many people with handicaps "live down" to low expectations and reduced opportunities. second, negative stereotypes of people with handicaps are strengthened as people observe the way some socially sanctioned "helpers" treat them and the negative results of opportunity deprivation on their lives. The two negative results work together to strengthen each other. Everybody loses. People with handicaps are blocked from potential growth - a person's label becomes a life sentence. And society and its services fail to learn more effective ways to support and teach. Left to itself, the vicious circle becomes more and more powerful as it feeds on itself.



There is an important use for vicious circles. If we can understand them, we can work systematically to reverse their effects. Ignoring the vicious circle focuses attention to its most obvious part, the handicapped person's assumed deficits. This over-attention leaves only one target for the change - the person - and few ways to accomplish it. With few effective tools for change, we are likely to become preoccupied with describing what is the matter with people at the expense of working to change it. This breeds hopelessness.

Attending to the whole vicious circle gives us more targets and tools for change. We can work to change expectations: our own in the short run; the larger society's in the long run. We can work to expand the opportunities available for handicapped people. And, in the context of expanding expectations and opportunities, we can work to change the person who is handicapped.

Consider this example of reversing a vicious circle (described in Gold, 1976). Marc Gold, a University of Illinois researcher, designed a training program to teach 22 long-term institution residents, 15 of whom are labelled severely or profoundly mentally retarded*, and all of whom are blind, or deaf and blind, to perform a complex industrial assembly task. All 22 people learned to perform the task effectively (in terms of accuracy) and moderately efficiently (in terms of rate of production per hour).

The success of this training effort rests on four assumptions which were sufficient to reverse the vicious circle.

1. The researchers selected a task that challenged what "every body knows" about severely handicapped people's vocational ability. Rather than a trivial task, they chose a task that would require special training for any worker regardless of intelligence (positive beliefs about people with handicaps).
2. Everyone was seen as a learner. The teachers expected that all 22 learners would successfully perform the task if they were given adequately powerful instruction (well defined, expanded expectations).
3. No one was excluded from training and each learner had as much opportunity to learn as was necessary (increased opportunity) . **
4. The project staff recognized that the possibility of people learning depends on the teacher's ability to design instruction and modify teaching strategies when they did not work. Gold states this in two principles:
 - the more difficult it is for a person to acquire a task, the more a teacher must know about the task; and
 - the more the designer of training knows about the task, the less prerequisites are needed by the learner.

The consumer is always right; if a person is not learning, the teacher must change his/her approach. Under these conditions, people with handicaps teach their teachers how to teach more effectively (powerful teaching).

* IQ scores for the group range from 17-52.

** In fact, the learner who mastered the task most rapidly took 9 trials; the learner who required the most teaching to master the task took 194 trials. Interestingly, no significant correlation was found between measured IQ and ability to learn this task.

But change did not stop in the work situation. In a film interview*, program staff document further reversal of the vicious circle. They note that the training program demonstrated that the people trained did not "live down" to living unit staff's expectations. Despite initial skepticism, everyone learned. Once this became clear, it was no longer possible for staff to hold the same diminished expectations. They began to raise their expectations and expand opportunities for learning in other areas. A "virtuous circle" - in which everybody wins - has been initiated.

Normalization is important because it gives us a tool for identifying, analyzing, and reversing the vicious circles that trap people with handicaps. It guides understanding of how people become negatively valued and creates opportunities for them to be revalued. This results in:

- the challenge of higher expectations
- increasing opportunities for choice and support
- handicapped people acquiring more socially valued characteristics.

Exercise:

Try following a few prejudiced beliefs through the vicious circle. Here are three prejudices to start with; add at least one of your own.

- A.
 - 1. "Everybody knows that no one will provide foster care or be an adoptive family for a severely handicapped adolescent."
 - 2. "Everybody knows that people labelled trainably mentally retarded can't learn to read."
 - 3. "Everybody knows that Tony won't ever be able to sit up and eat solid food."
 - 4. "Everybody knows..."
- B. Now think through some ways to reverse each of the vicious circles you've described.
- C. For some real life descriptions of practices/accomplishments that challenge these prejudiced beliefs, see:

For circle #1: Martha Dickerson, Our Four Boys:
Foster Parenting Retarded Teenagers.
Syracuse: University Press, 1978.

* "Try Another Way", Indianapolis, Indiana, 1976,

For circle #2: Robert Meyers, Like Normal People.

For circle #3: Robert Perske, et. al., Mealtimes for the Severely and Profoundly Handicapped.
Baltimore: University Park Press, 1977,

To read about 34 other ways in which vicious circles are being unwound, see The President's Committee on Mental Retardation, The Leading Edge: Mental Retardation Programs That Work, Washington, D.C., 1979.

IMPLEMENTATION OF THE NORMALIZATION PRINCIPLE

A good understanding of the normalization principle rests on a description of its practical implications. The next six sections describe program practices which implement the principle of normalization.

Implementation requires that a program work to avoid devaluing responses to people with handicaps. Three of the most harmful habitual responses are:

1. dehumanization: treating people with handicaps as if they were less than fully human;
2. age inappropriateness: treating people with handicaps as if they are, and always will be, children; and
3. isolation: segregating people with handicaps from valued communities and valued people.

Understanding each of these patterns of devaluation helps define positive practices to insure that people with handicaps experience dignity and individual respect, age appropriate settings and practices, and as much participation in the life of valued communities as possible.

In considering each of these topics in turn, we will be concerned with what a particular practice does to or for people with handicaps - with what a practice signals about their status and identity.

The signals a program sends will have a powerful long-term effect on public attitudes toward devalued people. If the goal is to increase the level of public acceptance of people who are seen as different, the message sent by what we do is as important as what we accomplish.

DIGNITY AND INDIVIDUAL RESPECT

CONDITIONS CONTRIBUTING TO DEHUMANIZATION

Dehumanizing practices rob a person of individuality, rights and dignity. They interpret people as less than human and deprive them of the opportunity to learn appropriate self-expression. Dehumanizing conditions are particularly oppressive in any setting where a person spends 24 hours a day. They are also a special concern in the place a person makes his/her home because home is where we most expect to be valued for ourselves and to be allowed room to express our individuality.

Space and Settings. Dehumanizing interactions are fostered by space arrangements that make it difficult for people to experience personal space and privacy. For example:

- Sleeping arrangements that permit no choice as to whether or not one will share a room or have one's own room.

Toileting and bathing arrangements that do not promote privacy.

- Living space which consists of large "dayrooms" with nothing but benches or chairs.
- Food preparation and eating arrangements that encourage "mass feeding" with few choices of menu or options to cook for oneself.

Lack of adequate space for personal possessions, including lack of space and opportunity to express one's preference for furnishings and decor.

- Controls for lights, water temperature, television set, stoves, etc. which cannot be easily operated.

Devaluation is signaled by features that suggest that the people in the program are dangerous, or even subhuman. For example:

Security features such as bars, safety screens, wire mesh, locked doors.

- Furniture, equipment, floor and wall coverings which are designed to be "indestructible" and "easy to clean".
- Walls and fences.

- Use of dangerous, condemned, or obviously dilapidated buildings.

Groupings and Practices. Dehumanization is promoted and signaled by a variety of "mass management" practices, such as:

- A predominance of large group activities.

Scheduling most activity for people as members of a group with little time and programmatic support to develop individual initiative or one-to-one relationships.

Grouping people for recreation and leisure time activities on the basis of broad categories such as assumed "functioning level" rather than on the basis of individual interests.

Regimented practices such as walking in line, group bedtimes, group toileting, etc.

Pools of clothing, shoes, toothbrushes, grooming aids, etc., rather than those the individual chooses and maintains.

Formal or informal "uniforms".

A large number of rules, often justified by the fact that "many people live here".

Exclusion from decision-making about activities or schedules.

Language. Dehumanization is created and signaled by spoken and written language habits which either fail to promote individuality or equate people with labels. For instance:

- A group of people, maybe even the place they live, is characterized by a label, such as when a group is called "non-ambs", "behavior disorders", etc.
- An individual is characterized by a label, such as when he/she is called a "TMR", a "CP", a "schizophrenic".

An individual or a group is referred to by an archaic term like "mongoloid", "borderline", "high functioning" or "low functioning".

People are not called by name, or are inappropriately called only by first or last name. •

Style of communication can dehumanize too. For instance:

- Most communication is addressed to a group.
- Most staff-client communication consists of instructions and commands.

Most staff-client communication in a living place is formal.

ENHANCING DIGNITY AND INDIVIDUAL RESPECT

The simple absence of dehumanizing conditions does not guarantee a person dignity and respect. All program elements should actively promote the development of people's ability to choose, the expression of individuality, and positive, personalized interactions.

Individualization. One of the most dehumanizing effects of institutional life is the unrelenting experience of self as a part of a mass. In order to develop a sense of worth as an individual, a person needs opportunities for self-expression and time apart from a group. If this is to happen, a staff needs to make extra effort to change its program to meet changing individual circumstances instead of expecting people to change to fit the program. For example:

Space arrangements and program practices encourage self-expression in furniture choice and arrangements and in selection and display of decorations. There is adequate space for people to use or display at least some personal items of furniture and decorations, and there is adequate storage space for other possessions and furnishings.

- Space arrangements not only permit privacy but also promote a clear sense of personal space. Staff do not violate personal space without invitation or permission.

All facilities are physically accessible to people with mobility limitations.

- There are active efforts to make program space, especially living space, not just physically comfortable but pleasing and even beautiful.
- Each individual program plan is based on personal knowledge of the client and has at least some important features that respond to him/her uniquely.

People can choose their companions for leisure time activity and have a say in choosing whether or not they will have a roommate and who their roommate(s) will be.

There are age-appropriate celebrations or personally significant events such as birthdays and special accomplishments.

Particularly for people with significant difficulties in communication, staff work to interpret individual preferences and to respect them. There is a priority on assisting such people to develop alternative ways to express choice. For instance, people are not only taught symbols or signs to signal basic needs but are also assisted to communicate preferences as soon as possible.

- Special equipment to assist posture, mobility, communication or control is highly individualized. Appliances and equipment are comfortable, well fitting, and designed and applied to minimize stigmatizing appearances.

Developing Choice. People with handicaps, especially those who have been institutionalized for long periods, often need systematic assistance to develop their ability to choose. This can be indirect - as when a consequential decision is left up to a person or a group - or direct - as when a person with extremely limited self-expression is taught to signal a preference between one type of food and another. For example:

The physical setting offers the widest possible variety of opportunity for choice and individual and collaborative decision-making. For instance, controls for water temperature, lights, radios, stereos, television, cooking and snack preparation equipment, etc., are accessible. People who do not know how to use them are systematically trained to do so.

People have free time with access to a variety of different leisure and recreational activities and equipment and are expected to choose among different activities for themselves. This includes the option to choose no activity. A person who apparently expresses no choice is either taught to do so, or effort is made to understand the person's unconventional methods of communicating.

There are a minimum of imposed rules in people's home setting. Issues effecting group life are decided by the affected group whenever possible. Group decisions cannot violate others' rights.

- Program practices are designed to challenge people to take appropriate risks.

The person's human and legal rights are not just the subject of notification. People are systematically taught to understand their rights and the means of protecting them. All those who are interested have access to training in the skills of decision-making and active citizenship as a part of their program.

Except perhaps for very young children, people are present at all individual program planning meetings and reviews which involve them. A person's inability to be present and participate in individual program planning is actively addressed in his/her individual program plan.

People are encouraged to exercise the rights and entitlements of citizenship, including voting, free communication, freedom of movement, etc.

All restrictions of freedom of movement, freedom of communication, and other rights should be done on an individualized basis by competent authority and for just cause. Their reversal should be considered as potential targets for individualized programs.

Positive Interactions. Positive staff-client interaction has different characteristics in different settings. However, in all situations staff interactions can be described as open, direct and sincere. People are not "talked down" to either by choice of words or tone of voice.

In a work or structured learning situation, the level of formality is appropriate to the activity and the ages of the participants.

In the home or residential setting, at least some staff interactions can be described as warm and personal. Staff genuinely share some of their life space and personal time with residents. There are few, if any, age inappropriate distinctions between "staff" and "residents" - such as "off limits" areas, staff bathrooms, uniforms, etc. Children are treated with personal affection by at least some staff who spontaneously play with them. Young children are physically held.

People of all ages live in a heterosexual world. Children see a range of positive male-female interactions in their residential settings. Young adults have increasing choice of individual relationships with members of the opposite sex. Adults have opportunities to experience personal relationships, including the choice of intimate relationships, with people of the opposite sex.

People interact with one another in a variety of ways, whether on a person-to-person basis, in small groups, or in larger groups. In each setting the tone of interaction is positive whether it is formal or informal.

AGE-APPROPRIATENESS

CONDITIONS CONTRIBUTING TO AGE-INAPPROPRIATENESS

For most of us, social expectations, opportunities and experience of self change as we get older. Few of us have to grow up all at once; the typical patterns of our culture wisely challenge us to develop a step at a time. The rhythms of our day, week, and year change as increasing age brings higher expectations for productive, responsible behavior and more choices of where, how, and to what extent those expectations will be met. There are social milestones which clearly signal the occasion of change: the first day of school, the first job for pay, religious confirmation, the driver's permit, the voter registration card, the first (legal) drink. There are also more gradual changes, less notable but equally significant in marking changing expectations and status. The gradual exchange of less complex for more complex toys, and of toys for tools, signals increasing maturity. Clothing styles change, often subtly, to reflect increasing age.

People whose development is remarkably slower have difficulty responding to changes in expectations at a typical rate. For example, children with mental retardation may be very slow to develop the skills required to play with complex toys. Their continuing use of toys and activities appropriate to a much younger age becomes a sign of their being "behind". Service practices can exaggerate this by providing cues and social reinforcement for age-inappropriate appearances and behavior. Programs should provide extra support to assist people to meet the large and small milestones of change, which reflect increasing age.

Age-inappropriate practices treat handicapped people as if they are, and always will be, children. It is not uncommon for people to explain another's continuing dependence by comparing him/her to a child, although it is inaccurate and devaluing. Thus, an elderly person who easily becomes confused is seen as being in a "second childhood" and a person with mental retardation may be described in a book titled *The Child Who Never Grew*. This comparison can become the basis for a vicious circle in which adults who are seen as children are treated like children and continue to behave in ways that reinforce their image as children.

Further confusion on this point arises from a convention of intelligence testing: reporting the number of items a person accurately completes on a standardized test with a summary number called "mental age".

A 25-year old person who has not done well on such a set of tasks might be labelled as having a "mental age of two". From this, it is easy to make a leap to the illogical and unjustified conclusion that this person "has the mind of a two-year old". This error leads many people to resist efforts to provide more age-appropriate activities and expectations because it seems unfair to treat someone who is "really only two years old" as if they were 25. However well intentioned, this mix-up of test scores and personal identity is damaging to people with handicaps.

Space and Settings. Age-inappropriate expectations can be communicated to people with handicaps and the public by building features. Here are some examples.

- Adults spend their days in a building constructed as a school for young children.

Furnishings are appropriate to younger people.

- Decorations and color schemes in adult areas suggest childhood.
- The physical environment does not make age-appropriate demands for good judgment, adaptation, and increasingly complex behavior.

Groupings and Practices. Age-inappropriate groupings make it hard for programs not to treat at least some participants age-inappropriately. For example, when:

- Children and adults live together in a situation where both are subject to the same people in authority.'
- Children of very different ages or children and adults are grouped together for major role-defining activities, such as work or education.

Children of very different ages or children and adults are grouped together as participants in formal recreation activities. (This is different from a situation in which older children or adults take appropriate roles in play with smaller children.)

Age-inappropriate practices hold back individual development and signal devaluation to the public. For example:

- Time is scheduled age-inappropriately, as when school-aged children are deprived of six full hours of schooling or

adults are deprived of at least eight hours a day of activity the public would see as productive (working, learning, or a mix).

A disproportionate amount of time is spent in recreational/leisure activities relative to age.

Recreation and leisure activities happen at age-inappropriate times, as when adults spend time designated for work or vocational training in recreational activity.

Daytime activities are age-inappropriate. Older children spend school time engaged in activities which would be appropriate for early education or primary grades. Adults do not have the option of meaningful, paid work and may be exposed to approaches to learning which are most appropriate for younger people.

There is minimal concern with the quality of performance or productivity. The expectation is "it's enough for them just to try". This disregards the status a person can earn for excellence in at least one area of activity.

- There is minimal concern with the future impact of activity. For instance, adults involved in vocational training are taught to perform trivial jobs which have little or no chance of being a way for them to earn a living wage.
- Activities selected for teaching are age-inappropriate. For example, an adult may need to learn how to pour. If this is taught in a sandbox with pails and shovels, it loudly signals devaluation. The same skill can be developed more age-appropriately in other ways, for instance, through cooking or potting plants.

Programs use age-inappropriate materials and equipment. A person of more than primary school age need not learn counting with preschool toys; he/she can be taught in the context of an age-appropriate activity such as setting the table, or on the job.

People are furnished clothing which is age-inappropriate or limits choices to one or two styles for all.

Language. Age-inappropriate perceptions are created and reinforced by language habits such as:

- Referring to adults as "children" or "kids".
- Labelling people or programs in terms of assumed "mental age" or "developmental age".

- Program or setting names that suggest childhood, though adults are served.

Paternalistic tone and patterns of speech. (Talking like the stereotype of a kindergarten teacher.)

ENHANCING AGE-APPROPRIATENESS

Maintaining age-appropriateness requires special effort. It must be a conscious focus in the design of program schedules and activities and an important factor in the development of individual program plans.

Program Scheduling. Scheduling refers to the balance of activities that are potentially available to people in a program. An individual schedule of activities may be very different from the options available, depending on individual need and choice. However, the program should arrange itself overall so that age-appropriate choices are not limited by resource patterns.

- Young children have the option of a balance of early education, small group, and individual play.
- School-aged children and adolescents have the option of six hours of school, with appropriate vacations, including opportunities for travel and a variety of leisure time activities.
- Adults have the option of an eight hour productive work day with compensatory education available either instead of time at work or after work time. Adults have appropriate days off and annual vacation periods with opportunities for travel.
- Daily routines of waking, mealtimes, and bedtimes are not regulated to deny people age-appropriate ranges of choice; i.e., as people get older they have more choice of bedtime and, at least on days off from work or school, more choice of rising times and mealtimes.

Activity Selection. Age-appropriateness is a consciously applied criterion in the selection of teaching and living activities and materials. This poses challenges to programs serving adults with very limited abilities.

Activities are designed to teach skills by age-appropriate processes and at appropriate times. For instance, a person who needs training in self-care skills receives it individually at appropriate times (on waking or before bed)

in appropriate places (his/her own bedroom or bathroom) rather than, for instance, in a classroom group at midday.

- Materials are selected to reinforce an accurate perception of a person's chronological age. This often means shopping for adult materials in a hardware store or a grocery store rather than ordering them from a catalog of child-imaged "Developmental Materials".
- A program that supplies residents with clothing, grooming aids, and perhaps even gifts, insures that the range of selection offered is age-appropriate.
- When an activity relies on systematic arrangement of consequences, age-appropriate reinforcers are selected.

Individual Program, Plans. A person's individual program plan (IPP) reflects a concern for age-appropriateness. For example:

- IPP's identify age-inappropriate behaviors, appearances, and possessions as potential targets for change.
- IPP's systematically support age-appropriate appearances. Especially when a person requires substantial assistance in dressing and grooming, the IPP does not just note need for assistance, but specifies that the person should be dressed and groomed in a fashion appropriate to chronological age.

IPP's identify developmental challenges which will elicit increasingly age-appropriate behavior.

- IPP's set criterion for successful skill attainment not just at simple performance, but at the achievement of the highest individually possible degree of age-appropriate style and grace. For example, a person is not only taught to keep her hair clean and neat, she is also helped to select a style that is individually flattering and fashionable in terms of her age.
- IPP's balance work, formal education, and leisure time in a way that is age typical. If an individual's need requires an age-inappropriate balance of activity, there is a plan directed at supporting or teaching the person skills which will eventually permit a more age-appropriate balance of activities.

Note. Many handicapped people have experienced near life-long deprivation of age-appropriate opportunities and expectations. This may show up in a preference for age-inappropriate activity - as when an adult

prefers to sing and listen to nursery rhyme songs, - or an attachment to an age-inappropriate possession, such as a child's toy or a teddy bear. In this situation, there is a tension between the need to support individual choice and self-expression and the stigmatizing effect of age-inappropriateness. The principle of normalization does not offer a simple, "right" answer like "take the teddy bear away". Instead, it directs attention to aspects of the situation that are under program staff's immediate control, such as the number of more age-appropriate choices of activities and possessions the program actively offers the person, the effects over time of social reinforcement of more age-appropriate choices, and the effects over time of guidance, teaching, and interactions with valued age-peer models.

PARTICIPATION

CONDITIONS CONTRIBUTING TO ISOLATION

Many service arrangements have moved people with handicaps away from valued age-peers, others move them away from their home communities, and some even isolate people from friends, relatives, and immediate family members. Programs exist to help people meet their individual needs in socially acceptable ways. If people with handicaps are to learn to meet their needs in the least restrictive possible relationship to their community, they must experience that community as an essential part of their learning. There are two dimensions of community life a person needs to experience:

1. the physical world of places and things; and
2. the social world of people and typical human groups.

On a technical level, there is good evidence that the more severely handicapped a person is, the more necessary it is that teaching be community referenced. This means that an instructional goal is not considered met until a person is able to perform the task in an acceptable way in a natural community setting (Brown, 1976).

But there is more to it even than this. Above all, the physical and symbolic isolation of people with handicaps from community life creates a sense of strangeness among typical community members. This can breed suspicion, and often outright rejection. If services are to be, in fact, least restrictive, a significant number of community members must support their development in natural communities. As long as isolation persists, social acceptance cannot develop.

Space and Settings. Many residential services for handicapped people were founded and grew when isolation was considered the "treatment of choice". For a time, isolation was justified by a belief that handicapped people need protection from the problems and dangers of community life. This soon turned to a belief that the community needs protection from costs and dangers allegedly posed by people with handicaps. The effects of such isolation are especially acute in services where people spend 24 hours a day. Programs which have inherited facilities developed on the logic of isolation must work against the weight of such physical features as:

- A location and pattern of travel which places many people a great distance from their family and community of origin. For example, a program which mostly serves people from an urban community is located in a small village miles away.
- A location which makes it difficult to get to and make appropriate and regular use of community resources, including

churches, shopping places, entertainment and eating places, public schools, community health care providers, etc. One program is located outside of town, about a mile and a half from the last stop on the bus line. This can lead to the creation of such resources within a facility which further reduces opportunity to experience natural community settings.

A facility size which congregates more socially devalued people in a single place than can easily be absorbed by the surrounding natural community. It is not uncommon for several hundred handicapped people to live in or near a village with a population only a little larger.

Location of facilities for people with different handicapping or other socially devalued conditions next to or near one another. This strains the ability of the natural community to assimilate program members into at least some aspects of their everyday life. In an extreme case, a residential program for 300 people shares a small city with facilities for 3,000 other people with mental disabilities and 6,000 prison inmates.

Groupings and Practices. People are isolated by practices which restrict their choice of relationships to other devalued people and the staff who serve them. Such practices deprive them of a wide variety of learning experiences, the support of valued peer models, many opportunities to exercise choice, the chance to become a part of a natural social network, and the challenge of contributing to community life. They include:

- Scheduling time so that people never leave the grounds of a residential facility.
- Designing activities so that people's only contact with natural community settings is in rather large groups (four or more people) .
- Working actively or passively to weaken the contact between a person and his family and relatives. For instance, a residence limits visiting hours and does not actively arrange home visits. The relationship between the program and family members makes a family feel unable to or irresponsible for relating actively to its handicapped member.
- Grouping people in such a way that they share facilities or programs with other devalued people who have very different special needs. One nursing home groups together young people with mental retardation with elderly people who require some personal assistance and people who are physically disabled. This group of people shares little besides a socially devalued status and isolation from valued relationships.

PARTICIPATION

If people with handicaps are to be accepted as participating citizens and offered the opportunity to lead culturally valued lives, a program must work systematically to overcome physical and social isolation. It must safeguard people against being unnecessarily isolated from their families, their relatives, their home communities, and their home regions.

Physical Presence. Before people can participate in the social interactions of a natural community, they must be physically present and involved in it. For some programs this is relatively easy; others, whose very locations are isolating, must be particularly creative. Some efforts to insure physical presence are listed here.

- The program is located in a place which makes it easy for people to get to and use a wide variety of valued resources.

The program is located so that it is easy for a person to maintain contact with his/her family and home community.

There are imaginative efforts to give people access to valued places. For instance, there is extensive provision for transportation and residences aggressively encouraging home visits, including finding valued homes to accept frequent visits from people who have no family contact.

Programs are kept numerically small and do not themselves congregate so many people as to make it impractical for those served to make frequent use of community resources. As well, programs are located far enough from other services congregating devalued people to minimize strain on a community's ability to integrate them.

Social Participation. Full community membership requires that people be active participants in a variety of individual and group relationships. Even people whose capacity for communication and mobility is very limited can and need to be part of a network of personal relationships with valued people. Some program supports for social participation include:

Program time is arranged to allow people opportunities for individual and small (two-three persons) group participation in community events and activities such as church services, entertainment, civic meetings, etc.

- People do not spend their days in the same area that they call home, and, except when individual needs are temporarily so substantial as to make it impossible, they participate in work or schooling in community settings. Children attend classes provided in the community by the public school; adults make use of community opportunities for productive employment and education.

- People learn to use generic health care and other service agencies and programs provide the minimum amount of services within their walls which is consistent with individual needs.
- Individual program plans include specific objectives to increase social participation in valued settings. Skills are developed to make a person an appropriate participant.
- The program makes some social participation a reality for everyone, regardless of his/her current ability. Social participation is not seen as an all or none possibility only for those who finally earn their way to it.
- The program has a wide variety of ways to develop and maintain a person's active involvement with family and relatives. When a person appears cut off from family and relatives, the individual program plan includes a strategy for attempting to revitalize family contact or involve the person with valued community members who can, to some extent, stand in place of the family.

PRINCIPLES INTO PRACTICE

Many institutional programs are operating in buildings that were built at a time when the basic service philosophy was to isolate as many handicapped people as possible in one place and keep them as cheaply as possible. Most of the people who grew up in these buildings had little in the way of individualized training relevant to community living and few had contact with typical people and community settings. Putting the normalization principle into practice is difficult in any setting, but working against the history of many institutional settings and their effects on residents is a major challenge. It requires careful planning based on a good understanding of the way vicious circles work.

Example:

Implementing the principle of normalization includes according people the dignity of risk. This means avoiding attitudes and practices based on the expectation that handicapped people would be endangered by the challenges of living and should be insulated from potential risks. Such overprotection becomes a self-fulfilling prophecy. People who are restricted to protect them from the world learn little about it. It is nearly impossible for anyone to develop effective problem-solving skills without taking risks and making mistakes. Overprotection can provide an excuse for unjustly depriving people of opportunities. For example, a person may be kept from community experiences because of a staff feeling that he/she is "not quite ready".

But taking sensible action is not always simple. Many handicapped people have significant difficulty figuring out some of the problems of

everyday life. People who have grown up without facing and learning from one small risk at a time have little opportunity to develop good judgment. While poor judgment itself is not a legal reason for restricting a person's activities without due process of law, it does pose a significant problem for an interdisciplinary team. There are two approaches to this problem that will not help:

1. Overprotection can continue, keeping people less able.
2. Protection can be withdrawn without planning for support, abandoning people to sink or swim on their own.

Both of these approaches provide more justification for the vicious circle of overprotection.

A constructive response requires the ability to individualize planning, training, and support. Blanket overprotection can be withdrawn when a program can cooperate with a person and his/her family to deliver training and assistance to help prepare for challenges and work through their consequences.

PUTTING IT TOGETHER

To think about program quality from the point of view of the normalization principle, answer these questions for yourself after you have observed the daily experience of participants and reviewed descriptions of the program. Remember, the test of program quality is not the completeness of plans or records in themselves but the way in which plans actually change the experience of participants.

1. What developmental challenges do participants experience?
Ask yourself: What do the people here learn from the variety and challenges of...
 - the physical environment;
 - the equipment and materials they use;
 - the use of transportation;
 - the type of activities provided and the attention, stamina, judgment, and standard of quality expected of program participants;
 - the responsibility participants are expected to assume for defining and promoting their own interests;
 - the responsibility participants are expected to assume for contributing to their program and to the community;

- the people participants relate to;
 - the participant's opportunity to experience community settings and use community resources?
2. Is the program a participant actually experiences sufficiently intense and specifically tailored to individual differences so as to be likely to increase ability to meet and grow from developmental challenges?
 3. How much time do participants spend...
 - outside the facility;
 - in typical community settings;
 - relating to typical citizens?

If a person has limited access to the community and its people, how does the program plan to increase community interaction...

 - by individualized training;
 - by providing in-community activities;
 - by working to reduce social barriers?
 - A. As a participant's competencies increase, how do his/her experiences, options, and surroundings change? Does successful completion of IPP goals result in real change?
 5. Are participants' appearances and behaviors positive in terms of the values of the larger society? Ask yourself: What supports does the program offer to promote positive appearances, including:
 - personal guidance and assistance;
 - training;
 - systematic exposure to positive models;
 - aids, equipment, supplies, appliances;
 - special emphasis on grooming or dress to compensate for negatively valued characteristics?
 6. Are program activities appropriate to the chronological age of participants? Ask yourself: Would socially valued people of this age...
 - be doing these things;

in these settings;

- at these times of day or week.

If activities seem inappropriate, what is the justification?
Does the program actually offer the choice of different
activities which are more age-appropriate?

7. How individualized is each participant's experience?

Do different people in the program actually experience
different schedules, activities, and supports based on
a decision about individual needs?

Do participants themselves actively participate in
deciding on goals, procedures, and practices which
affect them?

How many different kinds of individualized aids, appli-
ances, and competency extending tools and gadgets do
participants possess and use?

- How do participants personalize the space they live in...

- with personal possessions and furnishings;

by participating in decorating, painting and arranging
space?

'BUT, AREN'T THERE SOME CONTRADICTIONS?'

The principle of normalization has its critics. Some wonder whether
or not it responds to what is real for people with mental retardation,
especially those labelled "severely or profoundly retarded". These people
see three possible contradictions in the principle; discussing these con-
tradictions will further clarify our understanding.

Contradiction #1: Making People Normal

"The principle of normalization says people with handicaps should be
socially accepted and valued. But, isn't it devaluing to handicapped people
to try to make them normal?"

This criticism rightly points to the fact that people with handicaps
are often significantly different from other people and then questions the
normalization principle in calling for socially valued outcomes. This
criticism is based on two assumptions that conflict with today's realities.

1. Differences in appearance and behaviors cannot be substantially reduced; and
2. The only target of change is the handicapped person's deficiencies.

Two arguments can be raised about these assumptions.

First, recent technical progress reverses a long history of diminishing expectations for developmental progress. Disciplined application of teaching technologies and individualized design of supports for mobility, posture, communication, and control make it possible for many handicapped people to increase their competence and improve their appearance to a degree that few could have predicted. Developments in applied research make it impossible to predict how many more handicapped people will benefit, and in what ways.

Because the extent to which a person can develop culturally normative or culturally valued skills and appearances cannot be predicted, the normalization principle is stated as a clear and distinct challenge to expectations. It is up to non-handicapped people working in partnership with handicapped people to set the limit on how normative or valued the results of hard and creative work will be. Implementing the principle of normalization leads staff to seek the most valued possible appearances and behaviors for each individual program participant.

Second, the normalization principle is built on the belief that the quality of life for people with handicaps depends as much on the signals our services send about the identity of people with handicaps as on individual changes in behavior or appearance. This means that the immediate intent is to change the ideas and actions of people who plan, provide, and evaluate services

Values are shaped by program signals, and technical progress itself depends on changing values. Before much can happen, researchers, teachers, and other developmental specialists have to decide that handicapped people are worthy of individualized attention. They also have to free themselves of the confusion introduced by the idea of "cure". In the history of services to devalued people, "cure" has had an all or nothing quality to it. One was either "curable" or "incurable". This justifies neglect, or, at best, "humane" custodial care. Progress began with the realization that competency has many aspects which can only be defined and developed by seeing past an identity defining label - like "mental retardation" - to the many singular competencies that an individual can develop.

Normalization, then, is not something that is done to a person. It is a principle for designing and delivering the services a person needs. Services designed on the normalization principle are likely to result in increasing competence and social participation for individual handicapped people and in increasing social acceptance for handicapped people as a group.

Contradiction if 2: Denying People Special Help

"The principle of normalization says services should use culturally valued means, but if we treat people with handicaps the same as anyone else, they won't be able to develop."

Those who identify this contradiction are concerned with the call for culturally valued means. They point to the undeniable fact that people need a variety of help to develop. But, as defined, the principle of normalization does not deny the need for assistance. It only raises questions for those who design and deliver it.

People who are unable to maintain an upright position on their own need assistance. Some of that assistance may require appliances and equipment that are anything but typical in appearance. In this situation, establishing an appearance which is as normative as possible assists the development of other valued behaviors. It also requires means that are unusual, such as a positioning chair or a prone board. There is a trade off between two good things.

People who cannot vocalize need assistance, perhaps in the form of sign or symbol systems, to communicate their intentions. Here, again, there is a trade-off. Those who plan services agree with the handicapped person or his/her family that the accomplishment of being able to communicate intention outweighs the unusualness of the means.

People whose behavior is unusually disturbing may need assistance in the form of carefully arranged cues and consequences to increase their self-control. This kind of help might be negatively valued by many natural community members. However, if unchanged behavior would be even more negatively valued, it will make sense to make the trade-off in favor of a less familiar means.

In deciding whether it is worth trading a less valued means for an accomplishment, there are three things to keep in mind. First, there are a wide range of ways to provide a person with most kinds of assistance. Program designers should work to select, or create, the least stigmatizing, most culturally valued possible means. For instance, behavior analysts have discovered lots of alternatives to popping bits of food into the mouths of people who can benefit from systematically engineered consequences. The rule of thumb should be: start with the most valued or familiar form of assistance that is likely to achieve valued objectives, and only move to a less valued form of assistance if adequate effort does not achieve the objective. Decisions regarding an unusual or stigmatizing means ought to involve the person to be served, and/or his representative.

Second, all of us need some assistance in our development, at least from time to time. As much as possible, assistance should happen at times and places where valued community members are served. As well, as much as possible, the same people should provide assistance to handicapped people as serve valued people. The need for separate "special" equipment, activities, staff, and facilities should be creatively challenged, and the challenge should be more vigorous the further away from a valued practice we

move. That is, it may be that a person needs a special piece of equipment - say a wheelchair. This does not necessarily mean that he/she needs special activities, or staff, and it should never mean he/she must use a special facility - though obviously the buildings he/she uses must meet the lawful standards of accessibility. Even a person who needs special equipment* individually designed activities, and uniquely qualified staff, seldom needs a special building. For instance, many multiply handicapped children now attend highly specialized classes in their neighborhood schools.

Third, there is no necessary connection between the right to most opportunities and the achievement of some sort of competency. For example, all children, regardless of the degree or severity of their handicaps are entitled, by federal law, to a free and appropriate public education. This right is not qualified by the attainment of a test score or the ability to toilet oneself. People who are labelled profoundly handicapped or severely behavior disordered can live in (adapted) typical apartments in community neighborhoods and develop the skills that they need there. They should not have to earn their way to a more normative setting (see McGee and Hitzing, 1976).

Our society, and our services, tend to underestimate the capacity of people with handicaps to respond to culturally valued situations. Services that have chosen more normative means have found that there are positive responses to the choice of a new setting - perhaps a smaller residence which can honestly be called a person's home.

Thus, the principle of normalization influences a program to select the most valued possible means from the range of available options.

Contradiction #3: Exposing People to Rejection

"There is nothing 'normal' about being handicapped. Most 'normal people' and most 'normal' communities do devalue and reject people with handicaps. It doesn't make sense to base a principle on a wish that other people would be more accepting than they are."

People who identify this contradiction have lots of evidence to back them up. Within this century, people with mental retardation have been blamed for "spreading degeneracy", including crime, poverty, dependency, and disease; they have been abandoned, neglected, and abused in segregating institutions; and they have been systematically excluded from almost every opportunity to participate in community life. But this does not necessarily contradict the normalization principle. In fact, it makes a foundation for it. Let's examine this idea in two ways.

First, community acceptance is not an all or none affair. Nobody is accepted by everybody, or needs to be. Everybody does need to be valued and supported by an interdependent network of people to whom, in turn, he/ she can lend some support and positive action. Once a person belongs to such a social network he/she has a better claim on the resources - at least the tolerance - of the larger community. This provides a lever for change. If we implement the normalization principle by working to make more and more

handicapped people participants in the lives of a variety of community members, they will begin to grow a network of relationships which not only provides support, but also changes the status of the person and the group he/she represents in the eyes of others. Over the long run, this will reduce the level of devaluation of people with handicaps.

Second, "mental retardation" need not be an all or nothing thing. Whether a person is accepted and valued only depends on a single fact about the person - such as a very slow rate of learning - if the person has developed no competencies to balance obvious differences and he/she is treated in ways that signal difference. The antidote to devaluation has two parts: work hard to identify and remove stigmatizing practices and symbols, and work just as hard to find ways of developing positive characteristics and offering status building experiences and settings.

BUT IS IT PRACTICAL?

Many people accept the logic of the principle of normalization but see it as impractical. They feel that there are already too many problems in the existing service system, and they believe that it is unreasonable for service providers and evaluators to become concerned with "ideal" conditions.

The principle of normalization is in tension with much of past and current reality. It questions many common practices. In this sense, it is an important tool for problem definition and priority setting. The tension can be creative: if we choose to make it so.

The principle of normalization is as practical as we are willing to work to make it. It sets a direction; it does not provide a highly detailed *road map*. *It calls for increasing the probability that, over time, handicapped people will more and more live with us as valued neighbors rather than as devalued clients.*

LEARNING MORE ABOUT NORMALIZATION

- The basic discussion of the principle of normalization is: Wolf Wolfensberger (1972). The Principle of Normalization in Human Services. Toronto: National Institute on Mental Retardation.*

* These books, and information about PASS 3 training, are available from the Training Institute on Human Service Planning, Syracuse University, 805 S. Crouse Avenue, Syracuse, New York 13210.

The historical perspective on services to mentally retarded people that provides one of the cornerstones of normalization theory is described in: Wolf Wolfensberger (1975). The Origin and Nature of Our Institutional Models. Syracuse Human Policy Press.*

- The principle of normalization is operationalized for purposes of program evaluation and planning in:
Wolf Wolfensberger and Linda Glenn (1975). PASS 3. Toronto: National Institute on Mental Retardation. (Volumes 1 and 2).*
- An alternative definition of normalization, emphasizing the use of culturally normative means, is found in:
Bengt Nirje (1976). "The Normalization Principle" in R. Kuget and A. Shearer. Changing Patterns in Residential Services for the Mentally Retarded. (Revised Edition). Washington: PCMR, pp. 231-240.

* These books, and information about PASS 3 training, are available from the Training Institute on Human Service Planning, Syracuse University, 805 S. Crouse Avenue, Syracuse, New York 13210.

REFERENCES

- Biklen, D., and Bogdan, R. (1976). "Handicapism in America". WIN, October 28, 1976, pp. 9-13.
- Brown, L., et. al. (1976). "The Criterion of Ultimate Functioning" in Hey, Don't Forget About Me! Res ton: CEC.
- Gold, M. (1976). "Task Analysis of a Complex Assembly Task By the Retarded Blind". Exceptional Children. 43 78-84.
- McGee, J., and Hitzing, W. (1976). "Comprehensive Service Systems" in National Forum on Residential Services. Arlington: NARC.
- Scheerenberger, R. (1978). Public Residential Services for the Mentally Retarded: 1977. Madison: National Association of Superintendents of Public Residential Facilities for the Mentally Retarded.
- U.S. D.C. (1977). Sheltered Workshop Study: A Nationwide Report on Sheltered Workshops and Their Employment of Handicapped Individuals. Volume I. Washington, D.C: Employment Standards Administration.
- Wolfensberger, W. (1977). "The Normalization Principle, and Some Major Implications to Architectural-Environmental Design" in M. Bednar, ed. Barrier Free Environments. Stroudsburg, Pa: Dowden, Hutchenson and Russ.